

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
YOUTH CAMP INJURY ILLNESS REPORT FORM**

Camp Name	Camp Address	Camp Certification Number
		Name of County or Baltimore City
*Victim's Name:	Victim's Age	Victim's Sex <div style="text-align: right;"><input type="checkbox"/> M <input type="checkbox"/> F</div>
*Name of Parent / Guardian:	*Remove personal identifiers before forwarding a copy of this report to DHMH.	Date of Occurrence (mm/dd/yyyy)

Briefly describe the incident and subsequent injury or illness:

Complete Section A or Section B but not both

Section A: INJURY

<p>Location of the incident causing the injury.</p> <div style="list-style-type: none; padding-left: 0;"> <input type="checkbox"/> Sleeping/Living quarters <input type="checkbox"/> Kitchen/Dining area <input type="checkbox"/> Shower/Toilet <input type="checkbox"/> Other building <input type="checkbox"/> Arts or Crafts area <input type="checkbox"/> Trail or Nature area <input type="checkbox"/> Archery area <input type="checkbox"/> Riflery area <input type="checkbox"/> Swimming area <input type="checkbox"/> Boating area <input type="checkbox"/> Horseback area <input type="checkbox"/> Sport or Recreational Field or Court <input type="checkbox"/> Campfire/Cookout area <input type="checkbox"/> Road/Highway <input type="checkbox"/> General Campgrounds <input type="checkbox"/> Primitive/Outposts Camp <input type="checkbox"/> Other (Specify): </div>	<p>What type of event caused the injury?</p> <div style="list-style-type: none; padding-left: 0;"> <input type="checkbox"/> Falling/Stumbling <input type="checkbox"/> Collision with person or object <input type="checkbox"/> Struck by another person <input type="checkbox"/> Struck by missile <input type="checkbox"/> Drowning or near drowning <input type="checkbox"/> Bite or sting by insect or spider <input type="checkbox"/> Bite or wound inflicted by animal <input type="checkbox"/> Contact with excessive heat or flame <input type="checkbox"/> Using a tool (including a cutting instrument) <input type="checkbox"/> Contact with sharp object other than a tool <input type="checkbox"/> Bite or wound inflicted by person <input type="checkbox"/> Vehicle accident <input type="checkbox"/> Other (Specify): </div>	<p>Activities at the time of the injury.</p> <div style="list-style-type: none; padding-left: 0;"> <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Archery/Riflery <input type="checkbox"/> Horseback Riding <input type="checkbox"/> Swimming <input type="checkbox"/> Boating/Canoeing <input type="checkbox"/> Hiking/Climbing <input type="checkbox"/> Competitive Sports/ Games <input type="checkbox"/> Fighting <input type="checkbox"/> Horseplay <input type="checkbox"/> Walking/Running <input type="checkbox"/> Riding in vehicle <input type="checkbox"/> Other (Specify): </div> <p style="margin-top: 20px;">Name and title of staff member(s) supervising the activity:</p>
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<p>Body Part Injured/Type of Injury</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;"></th> <th style="width: 15%;">Head/Neck</th> <th style="width: 15%;">Trunk</th> <th style="width: 15%;">Arm/Hand</th> <th style="width: 15%;">Leg/Foot</th> </tr> <tr> <td>Bruise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Burn</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Fracture</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cut/puncture</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sprain/dislocation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>(Specify):</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Head/Neck	Trunk	Arm/Hand	Leg/Foot	Bruise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cut/puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sprain/dislocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(Specify):					<p>Was safety equipment available for the camper's use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If yes, was the camper using the equipment properly at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Did a staff member witness the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	Head/Neck	Trunk	Arm/Hand	Leg/Foot																																					
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Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																					
(Specify):																																									

Section B: ILLNESS

Infectious or inflammatory disease <input type="checkbox"/> Respiratory infection <input type="checkbox"/> Gastroenteritis (diarrhea, vomiting) <input type="checkbox"/> Dental (toothache, gum abscess, etc.) <input type="checkbox"/> Ear ache or ear infection <input type="checkbox"/> Appendicitis <input type="checkbox"/> Seizure <input type="checkbox"/> Other (Specify):	Allergic diseases (asthma, pollen, foods, etc.) Specify: <hr/> Toxic disease (insect bites, poisoning, drug use, etc.) Specify:
Other conditions not listed in A, B, or C – Include the pertinent signs and symptoms. <input type="checkbox"/> Psychological disorders – Especially homesickness <input type="checkbox"/> Undiagnosed conditions – Fever of unknown cause, fainting, etc. <input type="checkbox"/> Other – Nosebleeds, indigestion, etc.	Signs and symptoms: <hr/> Who made the diagnosis?

Section C: GENERAL INFORMATION

What medical service was provided? <input type="checkbox"/> Examination with no further treatment <input type="checkbox"/> Antiseptic/Antibiotic <input type="checkbox"/> Anti-inflammatory/Analgesic <input type="checkbox"/> Supportive (bed rest, physiotherapy) <input type="checkbox"/> Gastrointestinal (antacid, laxative) <input type="checkbox"/> Antihistamine/Decongestant <input type="checkbox"/> Psychotropic (tranquilizers, etc.) <input type="checkbox"/> X-ray or diagnostic test on (date) _____ <input type="checkbox"/> Stitches <input type="checkbox"/> Cast or sling <input type="checkbox"/> Dressing <input type="checkbox"/> Other (Specify):	Where was medical service provided? <input type="checkbox"/> Treated in Camp Infirmary or First Aid Station <input type="checkbox"/> Treated in Hospital Emergency Room, Clinic Physician's Office <input type="checkbox"/> Admitted to hospital <input type="checkbox"/> Other (Specify): <hr/> Final Outcome: <input type="checkbox"/> No disability <input type="checkbox"/> Temporary disability <input type="checkbox"/> Permanent disability <input type="checkbox"/> Unknown <input type="checkbox"/> Fatal	Who provided medical service? <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> EMS Responder <input type="checkbox"/> Other (Specify): <hr/> Date camper was sent home from <input type="checkbox"/> camp or <input type="checkbox"/> medical facility: <hr/> Date and result of lab tests or x-rays:
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What changes were made in the camp, its environment, or its operation as a result of this incident?

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|---|---|---|--|
| <input type="checkbox"/> Restricted camper | <input type="checkbox"/> Rest periods increased | <input type="checkbox"/> Beds rearranged | <input type="checkbox"/> Individual isolated |
| <input type="checkbox"/> Insects sprayed | <input type="checkbox"/> Supervision improved | <input type="checkbox"/> Use of disinfectants increased | <input type="checkbox"/> Camp Area(s) restricted |
| <input type="checkbox"/> Poison ivy/oak destroyed | <input type="checkbox"/> Rules changed or added | <input type="checkbox"/> Repairs or improvements | <input type="checkbox"/> Protective devices |
| <input type="checkbox"/> Safety equipment | <input type="checkbox"/> No changes | | |

☐ Other (Specify):

Describe:

Section D: Information completed by

Print Name and Title	Date of Report (mm/dd/yyyy)
Signature	Phone number(s)
	During camp: Rest of the year: Other: